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ABSTRACT

Pursuant to a bill passed by the Iowa legislature requiring training for mandatory reporters of child abuse, this manual addresses the fundamental issues of identifying and reporting child abuse. Chapter 1 is an overview of the history of child abuse and how the current system of reporting has evolved. Chapter 2 is a basic primer on the physical and behavioral identification of physical abuse, sexual abuse, and denial of critical care. The process for documenting child abuse and making a report are reviewed in chapter 3. Chapter 4 summarizes treatment and prevention programs and philosophies. Each chapter has a review case and sample questions for use as study aids. A short quiz is provided at the end of the manual, which prospective reporters of child abuse can submit to the Iowa Child Abuse Research and Education Project in return for feedback and certification. (TE)

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Protecting Iowa's Children

A training manual for mandatory reporters of child abuse

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Protecting Iowa's Children

A training manual for mandatory reporters of child abuse

Charles Abel, Ph.D.
Randell Alexander, M.D., Ph.D.
Barbara Smith, M.S.

Iowa Code 232.69(3)

[A mandatory reporter] . . . other than a physician whose professional practice does not regularly involve providing primary health care to children shall complete two hours of training relating to the identification and reporting of child abuse within one year of initial employment or self-employment involving the examination, attending, counseling, or treatment of children on a regular basis. The person shall complete at least two hours of additional child abuse identification and reporting training every five years. If the person is an employee of a hospital or similar institution, or of a public or private institution, agency, or facility, the employer shall be responsible for providing the child abuse identification and reporting training. If the person is self-employed, the person shall be responsible for obtaining the child abuse identification and reporting training.

TOLL-FREE HOTLINE for the Iowa Central Child Abuse Registry:

1-800-362-2178.

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Acknowledgments

This training manual reflects the concern and caring of many individuals working for the interest of children. All too often child advocacy can seem like an uphill battle. Because of the efforts of many individuals in the state of Iowa, our children can expect a brighter and happier future.

Our special thanks goes to Alfred Healy, M.D., Acting Director of the Institute of Child Behavior and Development, and Director of the Division of Developmental Disabilities. Dr. Healy has been an integral part of this project from the beginning and indeed has made it possible. His vigorous efforts over many years on behalf of persons with developmental disabilities has allowed him a special understanding of families under stress.

In addition, we wish to thank Robert Bacon at the Division who aided us with their insights to make this manual a reality, as well as to Nancy Bradshaw, Julie Oltrogge and Barbara J. Smith for manuscript preparation. Special thanks goes also to Loretta Popp, a design artist at the Division, for designing the manual.

We are grateful to the pediatric residents and staff members in the social services department at the University of Iowa Hospitals and Clinics for help with field testing these materials, as well as to staff at these Iowa City day care centers: Friendship, Good Shepherd, Handicare, Kindercampus, Melrose and University Parents Care Collective. In addition we wish to thank Mark Albanese, Ph.D., Director of the Office of Consultation and Research in Medical Education, for his advice regarding instructional assessment.

Others who have contributed their time, energy and encouragement include David Schor, M.D., Ted Scurletis, M.D., Timothy Gibson of the Iowa Medical Society, Richard Caplan, M.D. and Louis Crist of the Division of Continuing Medical Education at The University of Iowa.

The Advisory Board for the Institute of Child Behavior and Development provided continuing encouragement in the preparation of this manuscript. University of Iowa administrators provided funding necessary to begin the project.

The many citizens who worked to pass House File 451 (the mandatory reporter training law) and the state legislators who passed this one of a kind law in the country, deserve particular thanks. It is our hope that this text book will provide a useful addition to the efforts to implement their intent.

The many Department of Human Services workers, county attorneys, judges, physicians, public health nurses, social workers and psychologists who have shared their cases over the years with the Child Development Clinic at the Division of Developmental Disabilities. They continue to be the "unsung" heroes in the major effort to limit the damage caused by child abuse. With hostility as a more likely

outcome than thanks, it requires patience and genuine interest in children to sustain the daily efforts of these child advocates in their many professional fields. Indeed, all mandatory reporters share in this commitment to children and families as a fundamental basis for a healthy society.

We wish to give special recognition to Timothy Barber-Lindstrom, Child Abuse Specialist, Iowa Department of Human Services, who extensively reviewed this manual.

Finally we wish to acknowledge the parents and children caught up in abusive situations. The cycle of abuse across generations and the pain that such abuse causes to both child and parent are difficult for most to appreciate. Something is lost with each episode of child abuse that can never be entirely put right again. Through early identification of child abuse, perhaps the hurts and disappointments of the child and family can be minimized and a more hopeful lifestyle begun.

Charles Abel, Randell Alexander, and Barbara Smith
June 1987

Introduction

The increasing awareness of the problem of child abuse has resulted in a demand for educational programs so that all citizens, especially those in the category of mandatory reporter, might better respond to children in need.

Acknowledging these concerns, the Iowa legislature passed a bill requiring that all mandatory reporters of child abuse must have two hours of training in the identification and reporting of child abuse within one year of initial employment and two more hours once every five years thereafter. Since this law went into effect in July 1985, efforts have been made to comply with this requirement. This training manual meets the requirements of section 232.69(3) of the Iowa Code 1985 for mandatory reporters.

The manual itself addresses the fundamental issues of identification and reporting. Chapter 1 is an overview of the history of child abuse and how the current system of reporting has evolved. Chapter 2 is a basic primer on the physical and behavioral identification of physical abuse, sexual abuse, and denial of critical care. The process for documenting child abuse and making a report are reviewed in Chapter 3. Chapter 4 is a summary of treatment and prevention programs and philosophies. Each chapter has a review case and sample questions for use as study aids. Answers to the short quiz at the end of the manual are to be sent back to the Iowa Child Abuse Research and Education Project. After sending in the quiz answers, you will receive:

1. Feedback on the content areas where you missed questions.
2. A certificate that you have passed the two hour training requirement on passing with 75% correct.
3. Entry into the computerized registry of persons who have fulfilled the training requirement. The service will verify your registration at your request.
4. Four written yearly updates on changes in the law and current research.
5. Notification of the need for retraining prior to the five year deadline.

Should you not receive a passing score, you will be given a second chance to pass the review without additional cost. The intent is for everyone to obtain sufficient knowledge to not only pass the review but to put the information into practice whenever child abuse is reasonably suspected. This text will be updated on a yearly basis. If you have comments or suggestions for improvements, please contact the authors.

This text is not intended to serve as a standard of professional care. Standards of professional care are determined on the basis of all circumstances and facts of individual cases and are subject to change as scientific knowledge, technology, and legislation evolve. However, it does reflect the view of the authors and many experts in the field of child abuse.

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

NANCY A. NORMAN, COMMISSIONER

June 23, 1987

Charles Abel, Associate Director
Institute of Child Behavior and Development
University of Iowa
Oakdale, Iowa 52319

Dear Dr. Abel,

The purpose of this letter is to commend the efforts of all who were involved in the development of the Iowa Child Abuse Research and Education Project mandatory reporter text. The text will greatly assist in training those professionals mandated by Iowa law to report suspected cases of child abuse.

The text provides all of the basic information on the physical and behavioral indicators of abused children as well as the family dynamics. In addition, the text meets the two hour requirement set forth in Iowa Code Section 232.69(3). Finally, the examples used in the text portray an accurate picture of the types of cases that are most likely to be seen by mandatory reporters.

I'm pleased to have been able to assist in reviewing the materials and I look forward to continuing to work with the project by providing information relating to changes in Iowa's child abuse statutes.

Sincerely,

Timothy Barber-Lindstrom
Program Manager
Child Protective Services

HOOVER STATE OFFICE BUILDING - DES MOINES, IOWA 50319-0114

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Instructions

1. Read each chapter, paying particular attention to the guiding questions at the beginning.

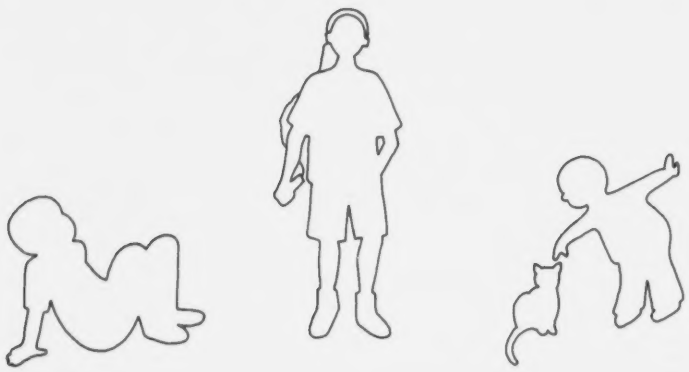
2. At the end of each chapter, read the review "case" and answer the questions, referring back to the text when necessary.

3. When you have finished all four chapters, answer the questions on the final review quiz, using the cards provided for your answers.

4. Send your review quiz answer cards to Iowa Child Abuse Research and Education Project, Institute of Child Behavior and Development, The University of Iowa, Oakdale, Iowa 52319. A certificate confirming that you have fulfilled the training requirement will be sent when the review quiz has been passed.

I

Child abuse: Yesterday and today
History, statistics, causes, and effects



AT THE END OF THIS CHAPTER, YOU SHOULD BE ABLE TO ANSWER THE FOLLOWING QUESTIONS:

What are some of the historical roots of child abuse?

What are the major points in the history of child protection?

What are the statistics on child abuse, nationally and in Iowa?

What children are most at-risk for being abused?

What adults are most at-risk for becoming abusers?

What are the effects of child abuse?

History

The little girl found a corner where one house projected a little beyond another and she crouched there, drawing her little feet close under her. But she was still cold. She did not dare go home, for she had sold no matches nor earned even one penny. If she should return home her father would surely give her a beating.

The Little Match Girl, Hans Christian Andersen, 1848

With the media attention that has been focused in recent years on child abuse one might have the idea that this social problem is a horror of modern times. In fact, violence, sexual abuse and neglect of children are not new phenomena. What is actually new, in the long view of history, is our concern with the legal right of children to be protected from abuse.

Child abuse under Iowa law includes four categories: physical abuse, sexual abuse, prostitution and denial of critical care (neglect). Physical abuse is physical injury, including bruises, abrasions, burns, welts, cuts, fractures, internal injuries, which is either nonaccidental and/or inconsistent with the explanation given for it. Sexual abuse is the commission by the caretaker (parent or others) of any of a wide range of sexual offenses with or to a child. Prostitution is allowing, permitting or encouraging a child to perform or offer sex acts for sale. Denial of critical care (neglect) is the caretakers' failure to act which impairs the physical, social or emotional growth of the child.

The roots of child abuse are found in many earlier practices. Some religious teachings have consented to the physical punishment of children. Infanticide, the killing of newborn infants, was practiced among widely diverse cultural groups to eliminate birth defects, to act out religious superstitions and as a birth control practice. For most of human history, children have been identified as the "property" of their parents. Aristotle said, "The justice of a master or a father is a different thing from that of a citizen, for a son or a slave is property and therefore there can be no injustice to one's own property." [1] In ancient Rome, the father had the right to sell, abandon, kill or offer a child as a sacrifice.

The industrial revolution shifted the concept of children as property from the home to the new factories. "The unwanted property/child was put to work under terrible circumstances...they worked long hours; they were chained to their post; they were permitted to eat but little and they were urged on to further effort by the blows of their overseers." [2]

The Mary Ellen case of 1874 is seen as the first legal challenge to the child-ownership rights of parents. A nurse visiting a tenement in New York City learned of a little girl who was being beaten and who was also seriously malnourished and neglected. When appeals to local law officials proved useless, the nurse and church workers contacted the Society for the Prevention of Cruelty to Animals. Mary Ellen was successfully removed from the home on the basis that as a member of the animal kingdom, she was "entitled to at least the same justice as a

common dog on the street." Out of this case grew the Society for the Prevention of Cruelty to Children. [3]

The invention of the X-ray in modern times provided a breakthrough in understanding how widespread child abuse was. In 1946, Caffey identified violence as the cause for a pattern in infants of subdural hematomas, a collection of blood under the skull, along with long bone fractures in infants, but the source of the violence was still not labeled.

It was not until 1953 that parents were formally identified as the cause of injury to children. The problem did not receive widespread attention until 1961, when six physicians made a presentation to the Children's Bureau in the Department of Health, Education and Welfare and the term "battered child syndrome" was first used. Said one of these physicians, "Knowing that pediatricians had for years been complacent about the problem of child abuse, it was felt that something had to be done to gain their attention and increase their desire to do something about the problem. The term 'battered child' was adopted to make an impact upon pediatricians and shake society loose from its complacent attitude." [4]

This description of the problem resulted in protective legislation. By 1967, all fifty states had laws based on recommendations by the Children's Bureau. In 1973, the federal Child Abuse and Protection and Treatment Act was passed, which included funds for research, prevention and treatment of the problem as well as a revised model of legislation.

Physical abuse was the first focus of laws, with other forms of abuse being added later. Iowa's laws followed this pattern. On July 1, 1965, Iowa initiated its first child abuse law which called for reports of suspected child abuse to be investigated by the Iowa Department of Human Services. In this legislation, citizens were encouraged to report physical abuse, but reporting was not required.

In 1975 most people who, in their jobs, frequently interact with children were identified as mandatory reporters who would be held legally accountable if they did not report suspected abuse. On July 1, 1978, thirteen years after this first Iowa Legislation, the law was expanded to cover sexual abuse and the denial of critical care (neglect). In 1984, sexual exploitation and prostitution were added to this legislation.

In 1985, a training requirement was added to the law. All mandatory reporters must now receive two hours of training within the first 12 months of employment, with an additional two hours of retraining every five years. This training requirement was the first of its kind in the country.

Statistics

Today 11 children died and 2500 were hospitalized as a result of child abuse and neglect in the United States. There was nothing unusual about the last twenty-four

hours. These same events - on average - occur each day in our society. But too many citizens have come to believe that child abuse is limited to these extreme cases. In fact, these victims of abuse may be only 12-15% of the estimated 2.5 million children who are abused or neglected each year. Despite all the attention the problem has received by the media, congress, state legislature, professionals and concerned citizens, child abuse is now a leading cause of death for children in our nation. The problem of child abuse has reached epidemic proportions.

Iowa is a part of this epidemic. In the 1986 reporting year, 9 children died as a result of abuse in our state. Also in 1986 there were 16,450 reports of suspected child abuse and neglect, with 30% of these confirmed, involving 6,245 children. These include 2,110 children physically abused, 1,004 sexually abused, 2,243 found to be neglected, and 888 victims of multiple abuse. The above statistics are based on the reports of suspected child abuse and neglect which were actually investigated. One could safely estimate that for every case of suspected child abuse and neglect reported, at least 3 cases are suspected but are never reported.

Causes of child abuse and neglect

"At first, many years ago, I thought maybe abusers were somebody else that lived over there, or somewhere else. Gradually, I found out they're not somewhere else. They're in the same city, the same town. Sometimes they're down the street. Sometimes they're people who are working along with you in the same hospital where you work. And you find out that all your early ideas about who the abusers were,

were complete nonsense. They're people just like we are. And we are all people who happen to live in ways that we were brought up to live, and the child abusers are no different from the rest of us except through the accidents of very early life experience and happenings..." [5]

Child abuse is not a problem of any one socio-economic or cultural group in our society. There are as many causes of child abuse and neglect as there are abused and neglected children. Nevertheless, it is possible to identify groups of children and adults who are at a greater than normal risk of becoming victims or perpetrators of child abuse.

High-risk children

Children who are most likely to be abused and neglected can be divided into three groups:

A. Essentially normal infants who are: 1) the product of a difficult pregnancy or delivery; 2) born at an inconvenient time from an unplanned pregnancy; 3) of the wrong sex; 4) too active; 5) too passive; 6) born during a period of severe family stress and crisis; 7) resembling an intensely disliked parent (i.e. a divorced spouse).

B. Infants and children who are "abnormal" in some way. Included are children born with: 1) significant prematurity; 2) with congenital deficiencies, abnormalities; 3) with a chronic problem, such as mental retardation, and/or physical handicap.

C. Children who can be either essentially normal physically or show very mild deficits, but who are described as being "difficult" or "different." They may be hyperactive, fussy, have abnormal sleep patterns or cry excessively and are seen generally as not responding to the caretakers.

While it is true that all the children described above are at higher than normal risk for abuse and neglect, it must be noted that only a small percentage of all premature, congenitally handicapped, or "difficult" children are abused or neglected. Steele reports: "It is our experience that a majority of abused and neglected children had originally been quite normal and that many of the emotional difficulties, evidences of retardation, and behavioral problems are the results of previous abuse and neglect rather than the causes of it." [6]

High-risk parents

While any parent, given the right set of circumstances, has the potential to abuse or neglect a child, some parents are at greater than normal risk. Some students of child abuse argue that the problem is a symptom of social and economic problems. Poverty, breakdown of the nuclear family, drug and alcohol abuse, increasing mobility of individual family members and jobs requiring work away from the home for extended periods of time, along with cultural and ethnic differences, are all associated with child abuse and neglect.

While the situations noted above may contribute substantially to the problem in any given case, it is impossible to attribute child abuse and neglect to the perpetrator's level of income (abusers are both rich and poor); residence (abusers live in both rural and urban areas); use of alcohol or drugs (abusers may or may not use alcohol or drugs); family relationships (abusers are found in single parent, two parent, foster parent and other home and family configurations); ethnic and/or cultural differences (abusers are found in all groups); or religious preference (abusers come from all religious backgrounds).

While abusive caretakers cannot be identified with any specific group, it is typical for them to have one or more of the following characteristics:

A. They are experiencing high levels of stress, such as loss of job, marital separation/divorce, intense intra-family conflict, illness, or death in the family.

B. They have unrealistic expectations of the child because they do not understand their youngster's developmental needs and stage of growth. They might, for example, expect the child to be toilet trained at 9 months of age, or expect a three year-old to know right from wrong.

C. They had poor role models when they were children. They may have been abused or neglected themselves, or they did not receive sufficient love and respect, leading to immature behavior, low self-worth and few skills to establish close trusting relationships with others.

Effects

Physical abuse and denial of critical care

> *I yelled at him and screamed at him all the time and then one day he laughed at me while I was screaming at him and I started slapping him in the face and I knew then that something had to be done.* [7]

While denial of critical care and physical abuse are separate categories of child abuse, they are considered together here because physically abused children are often neglected and vice versa. In addition, except for the physical injuries, which are in most cases not permanent, the long-term effects in both types of abuse are similar.

There is a wide range of injuries that result from abuse. Most children who are abused receive minor bruises, lacerations, or abrasions which will rarely lead to permanent damage and would often not be identified as abuse by an observer. The more extreme injuries involve the central nervous system and may cause death or permanent brain damage for survivors: seizures, mental retardation, hearing or visual impairments, cerebral palsy or learning deficits. The injuries to abused children can fall anywhere on or between the extremes. But these children are all at risk for having other problems, as well. When compared to children who have not been abused or neglected, they have:

- less adequate basic care, such as routine health care and hygiene
- more illnesses
- more hearing deficits

- more language delays
- lower IQ's
- more learning disorders
- more emotional disorders
- more difficulty dealing with social skills
- a higher school drop out rate
- more delinquent behavior
- a higher teen pregnancy rate

As we reflect on the long-term consequences of child abuse and denial of critical care, it becomes clear that all of society pays a price when children are mistreated.

Child sexual abuse

> *Mary's mother was almost hysterical when she called her private physician demanding that Mary, her 10-year-old daughter, be examined immediately for evidence of rape. Mary had just returned from a visit with her father when Mrs. Coffey was told of the possibility of sexual assault. The informant was the second wife of Mrs. Coffey's estranged husband. She said that Mr. Coffey had been sexually involved with both her daughter and Mary. The physician made arrangements to meet Mrs. Coffey and Mary in the local emergency room, where Mrs. Coffey related her daughter's story of the assault. "Her daddy took off Mary's clothes, covered her head with a sheet and rubbed something like vaseline on her privates".* [8]

Less is known about the effects of child sexual abuse because it is much less likely to be reported than other forms of abuse. There have been few studies of the long-term effects of sexual abuse. Research has shown that a number of factors influence how the abuse affects the victim: age of the child when the sexual abuse

started; the relationship of the abuser to the victim; how long, over time, the abuse has taken place; whether force was used, the type(s) of abuse inflicted, and the child's level of emotional development. Most of what we do know has been learned from adults who were abused as children and by professionals who make clinical judgments about the effects of sexual abuse on children in treatment.

The most common form of child sexual abuse is fondling between father and daughter, either over or under clothing. Other common sexual abuse situations involve daughters and stepfathers or a mother's boyfriend. Adult women sexually abused in childhood have described a variety of problems which have carried over into their adult lives, emotional problems which range from a lack of confidence to difficulty in developing relationships (with both men and women) to psychosomatic illnesses, depression and sexual problems.

Little is known about cases of mother-son, mother-daughter, and father-son sexual abuse and the effects of these interactions on children. More research is needed to address these problems areas. However, it can be assumed that the low rate of reporting abuse of a heterosexual nature would be even more exaggerated in cases of homosexual abuse.

Clinicians observe that sexually abused female adolescents react in a wide variety of ways: with anger, hostility, withdrawal, guilt, clinical depression, promiscuous behavior and drug and alcohol abuse. Many run away from home and some attempt

suicide. The physical effects have included pregnancy, venereal disease, and physical injury involving the female genitals and/or rectum.

Summary

The question of whether child abuse is more prevalent now than it was in earlier periods of history, is one that may never be answered. We are only beginning now to outline the extent of the modern problem. Accurate information about the past against which to compare our current estimates may be forever out of reach.

We are, however, beginning to understand both the short and long-term damage to individual children and to society when children are not protected from abuse. Mandatory reporters have a critical role in the effort to provide that protection. The information that follows on the identification and reporting of abuse should help these reporters.

Review

Read Gregory's story. Then write the answers to the questions in the space provided. If you do not know the answer, you can find the information you need at the page numbers after each question.

Sandy Jones was a third grade teacher at an elementary school in a middle class neighborhood. Gregory was in her class for the second year. Last year, he was shy and seemed emotionally very young for his age last year and simply was not catching on to basic skills. He was polite and quiet and in no way disruptive. Sandy met with Gregory's parents, and they seemed concerned and agreed to holding him back a year. This year Sandy was more concerned however. A vision screening had indicated a problem for Gregory, but he told her that he hadn't been to a doctor. When Sandy tried to call his home, Gregory always answered and said his parents weren't in. Then she noticed that he was frequently going without lunch and when she asked him about it he said he wasn't hungry. Finally, one winter morning she received a call at the school office and Gregory was on the phone. The pipes had broken in the house and he didn't know what to do. "Where are your parents," she asked. "My dad had a meeting in Florida," Gregory said, "And Mom went with him." "Who is staying with you?" Sandy asked. "No one," he answered. "I'm by myself this week."

Gregory's story might be an example of what type of child abuse? (p. 2)

_____

_____

When asked about Gregory staying alone, Gregory's father said, "Hey! This is my kid. I'll deal with him the way I want!" Which of the attitudes described as roots

of child abuse does his statement show? (p. 3)

_____

_____

In what year did child abuse laws in Iowa first cover denial of critical care and sexual abuse? (p. 5)

_____

_____

In what year were people like Sandy first required to report abuse in Iowa? (p. 5)

_____

_____

Gregory is estimated to be one of how many children abused in Iowa each year? (p. 6)

_____

_____

What are 2 possible factors in Gregory's life that might have made him at-risk for abuse? (p. 7-8)

_____

_____

What are some possible things in the lives of Gregory's parents that might have made them at-risk for treating him the way they did? (p. 8-9)

_____

_____

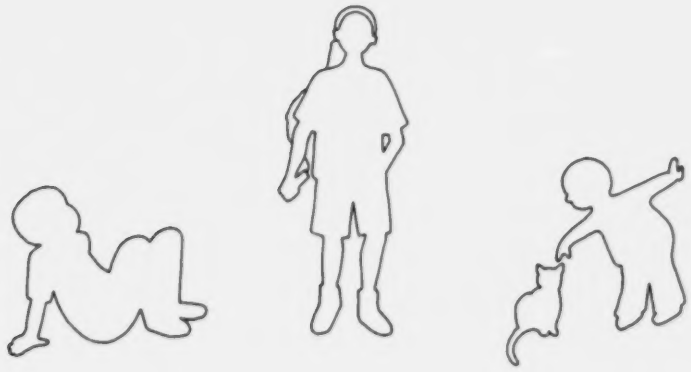
What are some long-term problems that Gregory might face as a result of abuse or neglect? (p. 10-11)

_____

_____

II

Recognizing and preparing to report child abuse



AFTER READING THIS CHAPTER, YOU SHOULD BE ABLE TO ANSWER THE FOLLOWING QUESTIONS:

What are the basic legal definitions of physical abuse, sexual abuse, denial of critical care and prostitution?

What physical signs might suggest child abuse?

What behavioral signs in the child might suggest child abuse?

How much does the mandatory reporter need to know about the exact legal category a particular incident might fall under?

"Looking back. I can see...yes...there were clues. I should have known there was something wrong. There were bruises on her arms and there was a wariness about her. We couldn't hug her or comfort her when she cried. She would draw back. The other staff and I didn't talk to each other about it. We didn't question the parents. We chose not to see." (Day care provider)

Teachers, day care providers and others who work with children often know when something is not right in a child's life. But it is often difficult to face the idea that we may be seeing signs of child abuse. We are often reluctant to take that first step, to admit even to ourselves, that yes, this might be abuse.

Because this reluctance is so common, the responsibility to identify and report abuse is now made clear in the law. Legally, if you are a mandatory reporter, you must choose to see. In Iowa, mandatory reporters covers are defined as follows:

1. The following classes of persons shall make a report within twenty-four hours...of cases of child abuse:
a. Every health practitioner who examines, attends, or treats a child and who reasonably believe the child has been abused.
b. Every self-employed social worker, every social worker under the jurisdiction of the department of human services, any social worker employed by a public or private agency or institution, public or private health care facility as defined in section 135C.1, certified psychologist, certificated school employee, employee or operator of a licensed child care center or registered group day care home or registered family day care home, foster parent, member of the staff of a mental health center, or peace officer, who, in the course of employment, examines, attends, counsels or treats a child and reasonably believes a child has suffered abuse. (See Chapter 3 for a complete list of mandatory reporters.)

All persons who fit this description need to be able to identify signs of possible child abuse. This chapter will deal with the signs, both physical and in the behavior of the child, which might lead one to suspect that child physical abuse, sexual abuse, or denial of critical care is taking place.

Physical abuse

Ed was a rough and tumble kid. Ten years old. He just looked like a scrapper and for a long time I went along with the idea that boys will be boys and he was just one of those kids who starts fights or attracts them. He always stayed at the playground after school until everyone else had left. There were a lot of absences. He would occasionally have a bruise on his face, but nothing that I couldn't pass off to a knock into a door or something. I mean you would say that once maybe. But then about four months into the year he was absent for a few days and he came back with a real shiner. "Ed," I said. "That must have been quite a fight." "Naw," he said. "I got hit by a baseball." But that day I had lunch with the gym teacher and he asked me "Did you see Ed's eye?" I said, "Yeah. Did he get hit by the baseball in your class?" "No," the gym teacher said. "He said he got hit by the outside mirror on his mother's car." That's when I started thinking back on the bruises on his face and felt I had to say something. We couldn't believe the extent of the bruises when we saw the medical report. He had always worn long-sleeved shirts and long pants--even in September when the other kids were still wearing shorts and tank tops. (Teacher)

The teacher used her observations of the child and her understanding of some basic signs of abuse to determine that she might be dealing with an abuse case that must be reported. For a situation to be reportable as physical abuse in Iowa, the reporter must believe that three factors are present:

Factor 1: A non-accidental physical injury has occurred, or an injury at variance with the history given of the injury has occurred. Physical injury under the law is:

"...damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition or damage to any bodily tissue to the extent that the tissue cannot be restored to a sound and healthy condition or damage to any bodily tissue which results in the death of the person who has sustained the damage."

Physical injuries include: abrasions, bruises, burns, dislocations, eye injuries, fractured bones or teeth, lacerations, reddening of surface tissue (hyperemia) lasting 24 hours

or more, scalds, sprains, or welts. Internal injuries include abdominal or chest injuries, brain damage, other central nervous system damage, and internal bleeding. A physical injury suffered by a child is "non-accidental" in the law if it was:

"...foreseen or which a reasonable person could have foreseen in similar circumstances, or which resulted from an act administered for the specific purpose of causing an injury."

Sometimes the child's or parents' explanation of how the injury occurred does not fit with the appearance of the injury. By definition the injury in child abuse is not an accident. This does not necessarily mean that the caretaker intended to hurt the child. It means that a reasonable and careful person would know that injury to the child could result from his or her actions. Physical abuse may result from over-discipline or from punishment which is inappropriate to the child's age or condition. It can also result from a caretaker not doing something, such as if a caretaker sees an older child playing very roughly with a baby and the caretaker does not step in to protect the baby.

Factor 2: The injury has been suffered by a child. A "child" is defined as a person under 18 years of age.

Factor 3: The child has been injured as a result of acts or omissions of the responsible caretaker. Caretakers are considered to be:

"...Persons responsible for the care of a child means: a parent, guardian, foster parent, babysitter; a relative or any person with whom the child resides, and an employee or agent of any public or private facility providing care for a child, including an institution, group home, mental health center, residential treatment center, shelter care facility, detention center or child care facility (i.e. day care center)."

Common myths about physical abuse

One myth is that "physical abuse" typically results in serious injury. Many dramatic cases of physical abuse have been reported by the media. Unfortunately these

horrific cases give the reader the impression that most physical abuse results in severe injuries. This is not the case. As in the case of Ed, the majority of physically abused children are not injured seriously enough to require hospitalization. Only 8-12% of all physically abused children reach that level of injury. The most common injury for physically abused children is bruising, not broken bones or severe burns.

A second myth is that a small child's skeletal system is quite fragile. The fact is that when small children accidentally fall out of a crib or down a flight of stairs, they are usually not injured. It takes a great deal of force to break a small child's bones.

Recognizing the signs of abuse

Child physical abuse results in physical injury, including bruises, abrasions, burns, welts, cuts, fractures and internal injuries. Any of these injuries could be the result of accidental injury rather than abuse. How do you determine whether an injury was accidental or caused by abuse? Unfortunately there are no hard and fast rules. However, there are some basic ways to help determine whether an injury is the result of abuse.

- **Where are the injuries located? Is this the type of injury that one would normally expect for the child's particular age group?**

Bruises on the elbows, knees, or shins, even on the forehead of a two to five-year-old, would be considered normal for the age group in most circumstances.

Shin bruises on a 2 month old, however, are suspicious because a child this young cannot move about enough to cause such an injury. Any bruises on the back, genital area, thighs, buttocks, face or the backs of the legs, are suspicious. (See figure 1.) A single bruise on the soft tissue of the cheek is a common suspicious mark.

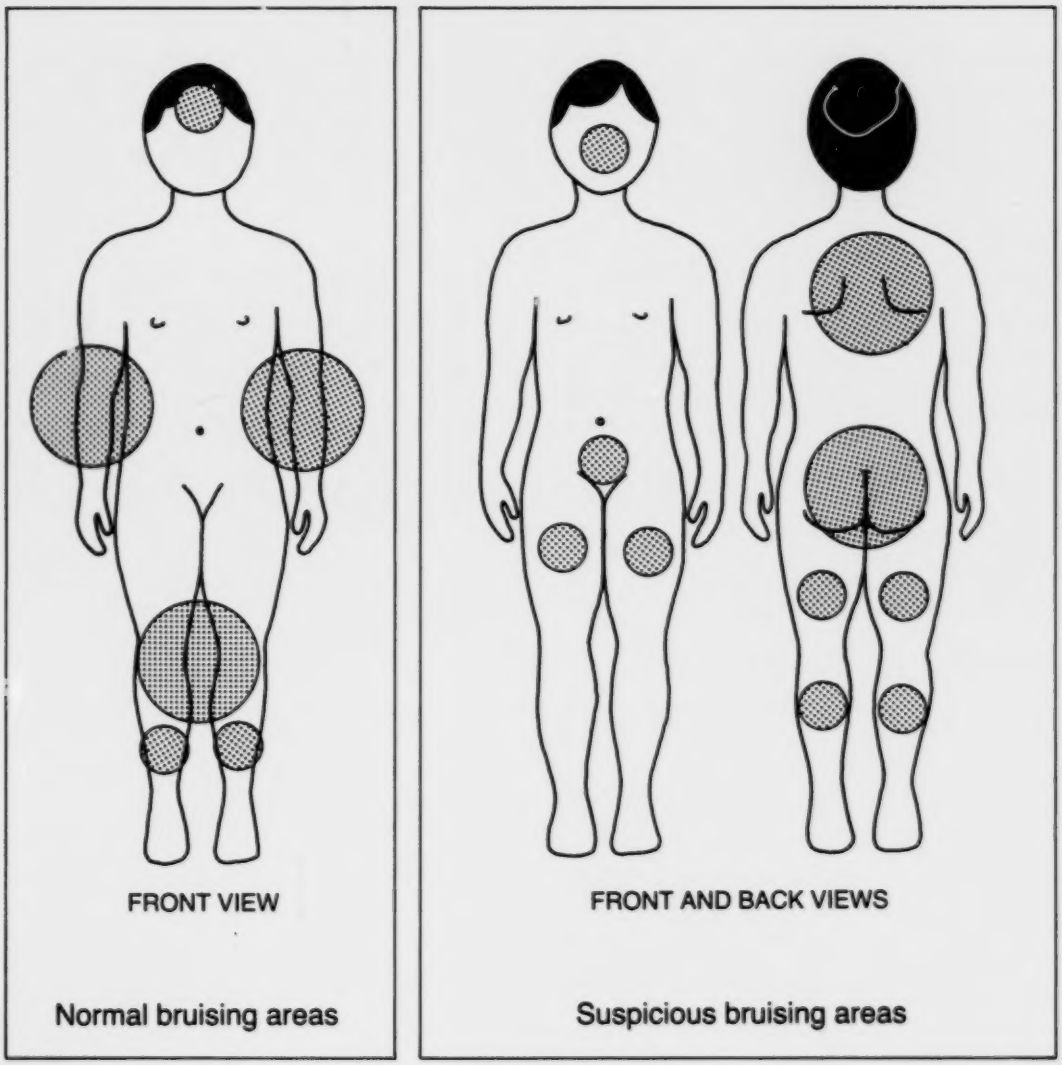


Figure 1

● **How many injuries does the child have? Are there several injuries occurring at one time? Or have there been several injuries over a period of time?**

One bruise can certainly be a sign of abuse. But the greater the number of bruises or other injuries, the more likely abuse could have occurred. The presence of several injuries at different stages of healing could indicate a pattern of abuse.

● **What is the size and shape of the injury?**

Many injuries are inflicted by familiar objects -- sticks, boards, a hair brush or belt. For example, a stick or rope could cause a bruise in a straight line. A bruise might also resemble the shape of a belt buckle, a looped electric cord or a hair brush. A small round burn could be caused by a cigarette or cigarette lighter. A small child's lips might be bruised and infected or there may be a chipped tooth. This could represent forced feeding on the part of a frustrated parent.

Here are some examples which might point to nonaccidental physical injury:

Unexplained Bruises or Welts:

Bruises and welts are injuries in which there is no breakage of the skin. In bruising, the small blood vessels beneath the skin break and blood leaks into the tissue. The bruise changes color over time. Welts are ridges or lumps on the body usually caused by a blow. With bruises and welts, some of the signs which might point to a nonaccidental occurrence include unexplained bruises or welts:

- on the face, lips or mouth
- in various stages of healing (bruises of different colors) [9]

Age of injury	Color
0-2 days	swollen, tender
0-5 days	red, blue, purple
5-7 days	green
7-10 days	yellow
10-14 days	brown
2-4 weeks	cleared

- on large areas of the torso, back, buttocks, or thighs
- clustered, forming regular patterns
- on several different surface areas (indicating the child has been hit from different directions)
- regularly noted as fading when the child returns to school after an absence, weekend or vacation

Unexplained Burns Which May be Seen As Redness, Blistering, Or Even Peeling Of The Skin

- cigarette burns, especially on the soles of the feet, palms of the hand, back or buttocks
- immersion or "wet" burns, including glove or sock-like burns, and burns on the buttocks or genitalia
- patterned or "dry" burns which show a clearly defined mark left by an instrument used to inflict them (e.g. iron)
- rope burns on the arms, legs, neck or torso.

Unexplained Lacerations (Torn and Ragged Cuts), Abrasions (Outer Layer of Skin Torn or Scraped Away) or Scarring

- to the mouth, lips, gums or eyes
- to the external genitalia
- on the backs of the arms, legs or torso.

Human Bite Marks, Especially When They Appear Adult Size or are Recurrent.

Unexplained Fractures (Broken Bones Which May or May Not Be Observed by the Nonmedical Person):

- to the skull, nose or facial structure
- in various stages of healing (indicating they occurred at different times).
- multiple or spiral fractures
- swollen or tender limbs
- any fracture in a child under the age of two.

Unexplained Abdominal Injuries:

- swelling of the abdomen
- localized tenderness
- constant vomiting.

Indications of child physical abuse in the child's behavior

Physically abused children have behaviors which can be signs for mandatory reporters to use in identifying abuse. Behavioral signs may exist alone or combined with signs of physical abuse. Behavioral signs of abuse include when the child:

- Is wary of physical contact with adults. In most educational settings, most children accept physical closeness to a teacher. The abused child

will often avoid it, sometimes even shrinking at the touch or approach of an adult.

- Becomes frightened or nervous when other children cry.
- Demonstrates extremes in behavior--extreme aggressiveness or extreme withdrawal.
- Seems frightened of the parents.
- States he/she is afraid to go home, or cries when it is time to leave.
- Reports injury by a parent.

FOR MEDICAL PROFESSIONALS

In most founded physical abuse cases in Iowa no medical, dental or other health care professionals are directly involved. However, when physicians encounter suspected abuse, immediate action is necessary. Most hospitals have established written procedures which guide the physician's action. One such "Medical Evaluation Checklist" follows:

1. History of injury
2. Physical examination of patient
3. Trauma X-ray survey on selected patients
4. Bleeding disorder screen on selected patients
5. Color photographs of selected patients
6. Physical examination of siblings
7. Official medical report in writing

8. Behavioral screening

9. Developmental screening [10]

Sexual abuse

I knew Jane before she started eating lunch here this year because I know her family, they go to my church. She's just seven. I was cleaning off the tables at the end of lunch one day and she was finishing up, sitting by herself, and I said "Boy you have really cleaned your plate," and she kind of mumbled something and I said "what?" and she said "I threw up last night." And I said "Gee that's too bad. Were you sick?" and I'm still wiping the tables and she said "My dad put his thingy in my mouth and then I threw up." (lunch room worker)

The types of caretaker-child sexual interactions that must be reported as child abuse are quite numerous and have been separated into a number of categories. While it is important to understand the various elements that are considered child sexual abuse, the mandatory reporter does not need to know all the elements that must be present for a particular type of offense. The mandatory reporter may in many cases only hear that something inappropriate for a child is going on. **For a sexual interaction to be reportable as child abuse, the reporter must reasonably believe that three conditions are present:**

1. That a sexual offense has occurred.
2. That the sexual offense has been suffered by a child.

3. That the sexual offense suffered by the child has occurred as a result of the acts or omissions of the responsible caretaker.

Classifications of child sexual abuse

Sex Act

In order for some sexual offenses to occur, there has to be a sex act. A sex act is defined in Iowa law as:

"...any sexual contact between two or more persons, by penetration of the penis into the vagina or anus, by contact between the mouth and genitalia or by contact between the genitalia of one person and the genitalia or anus of another person or by use of artificial sexual organs or substitutes therefore in contact with the genitalia or anus."

There are first, second and third degrees of sexual abuse. The degree of sexual abuse involves issues about whether force was used, whether a dangerous weapon was displayed, the age of the victim and the perpetrator, and the relationship between the victim and perpetrator.

Detention In a Brothel

It is a form of child abuse to cause a child to enter a brothel with the intent of having the child engage in prostitution.

Lascivious Acts With a Child

It is child abuse when any person 18 or older performs the following acts with a child for the purpose of arousing or satisfying the sexual desires of either:

1. fondle or touch the pubic hair or genitals of a child,
2. permit or cause a child to fondle or touch the person's pubic hairs or genitals,

3. solicit a child to engage in a sex act (see above),
4. inflict pain or discomfort upon a child or permit a child to inflict pain or discomfort on the person.

Indecent Exposure

It is a form of child abuse for the caretaker to expose his or her genitals or pubic hairs to a child or to commit a sex act with a third person in view of the child if it is done to arouse or satisfy the sexual desires of either party and if the person knows or reasonably should know that the act is offensive to the viewer.

Assault With Intent To Commit Sexual Abuse

It is a form of child abuse to assault a child with the intent to commit sexual acts with different degrees of guilt depending on the injuries resulting.

Indecent Contact With a Child

A person over 18 is guilty of this form of abuse if they do any of the following with a child, with or without the child's consent, for the purpose of arousing or satisfying either parties sexual desires:

1. Fondle or touch the inner thigh, groin, buttocks, anus or breast of the child.
2. Touch the clothing covering the immediate area of the inner thigh, groin, buttock, anus or breast of the child.

3. Solicit or permit a child to fondle or touch the inner thigh, groin, buttock, anus, or breast of the person.
4. Solicit a child to engage in any acts listed under lascivious acts with a child.

Incest

It is a form of child abuse to perform a sex act with a child whom the person knows to be related, either legitimately or illegitimately as an ancestor, descendant, brother or sister of the whole or half blood, aunt, uncle, niece or nephew.

Sexual Exploitation of Children

Another form of child abuse relates to the use of children in pornography. This code defines this abuse as:

1. ...when the person employs, uses, persuades, induces, entices, coerces, knowingly permits, permits, or otherwise causes a child to engage in a prohibited sexual act or in the simulation of a prohibited sexual act if the person knows, has reason to know, or intends that the act or simulated act may be photographed, filmed, or otherwise preserved in a negative, slide, book, magazine, or other print or visual medium.

2. ...when the person knowingly promotes any material visually depicting a live performance of a child engaging in a prohibited sexual act of in the simulation of a prohibited sexual act.

3. ...when the person knowingly purchases any negative, slide, book, magazine or other print or visual medium depicting a child engaging in a prohibited sexual act or the simulation of a prohibited sexual act ...

However, this section does <u>not</u> apply to law enforcement officers, court personnel, licensed physicians, licensed psychologists, or attorneys in the performance of their official duties.

Prostitution

This form of child abuse includes the acts or omissions of a person responsible for the care of a child which allow, permit or encourage the child to sell or offer for sale his or her services as a partner in a sex act. This is actually a fourth category of child abuse--along with physical abuse, denial of critical care and child sexual abuse. It is discussed here as a form of sexual abuse, because the signs and effects are similar.

It is important for mandatory reporters to have an understanding of the terminology used in describing child sexual offenses, and the range of sexually related behaviors between a child and caretaker that are considered offenses. It offers a clearer understanding of what society considers sexually inappropriate for children, when individual judgments may vary. However, it is important to understand that it is not the mandatory reporters' job to determine what category a particular incident fits into. Even Department of Human Services investigators or legal experts can be confused about the exact nature of an incident. Using a general understanding of the law, the mandatory reporter should be reporting incidents that reasonable judgment indicates are sexually inappropriate for a child.

Behavioral indicators of child sexual abuse

The sexually abused child may

- Confide in a relative, friend or teacher; the disclosure may be either overt or subtle and indirect.
- Become withdrawn and daydream excessively.

- Evidence poor peer relationships.
- Experience poor self-esteem.
- Seem to have phobias--unusual fears--especially of adults.
- Experience distortion of body image.
- Express general feelings of shame or guilt.
- Exhibit a sudden deterioration in academic performance.
- Show pseudomature personality development.
- Exhibit a positive relationship to the offender.
- Display regressive behavior.
- Have enuresis (wetting) or encopresis (soiling)
- Engage in highly sexualized play.
- Have a sexually abused sibling.[11]

Different behavioral indications may be more prevalent at different ages. For example, excessive masturbation and nightmares are signs that might be seen primarily in the younger child. The adolescent who has been the victim of sexual abuse might be involved in promiscuity or attempt suicide.

Physical indications of sexual abuse

Although nonmedical mandatory reporters are more likely to hear about sexual abuse from the child rather than see evidence, the National Center on Child abuse and Neglect provides a useful list of signs:

- difficulty in walking or sitting
- torn, stained or bloody underclothing

- complaints of pain or itching in the genital area
- bruises or bleeding in external genitalia, vaginal or anal area
- venereal disease, particularly in children under 13
- pregnancy, especially in early adolescence. [11, 12]

FOR MEDICAL PROFESSIONALS

Medical professionals should also note:

- Thickening and/or hyperpigmentation of labial skin (especially when it resolves during out-of-home placement)
- Horizontal diameter of vaginal opening that exceeds 4 mm in prepubescent girls (See figure 2)

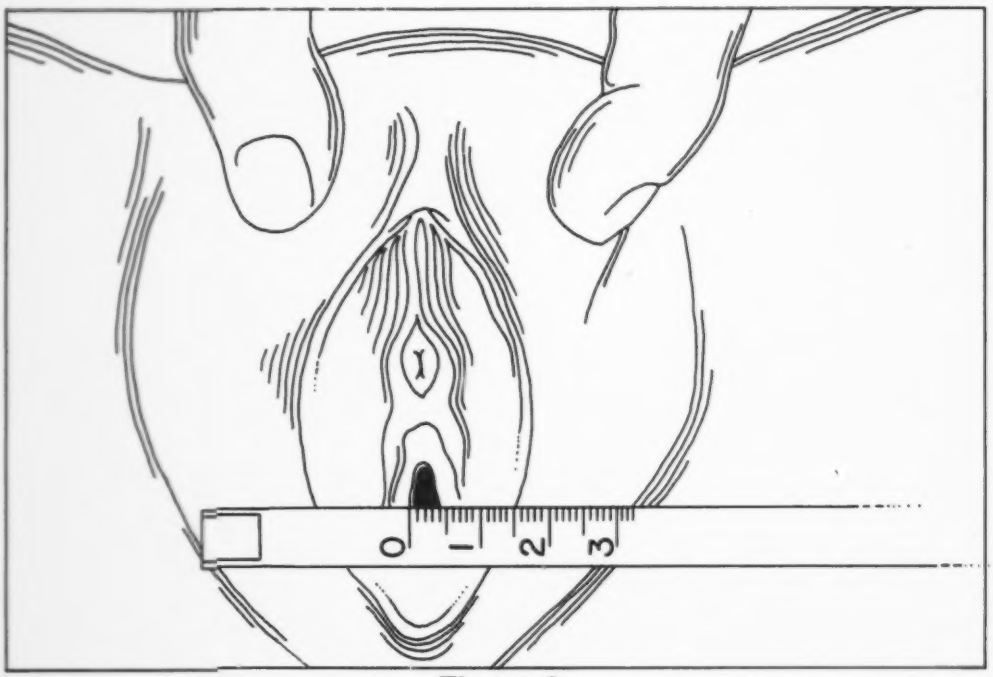


Figure 2

- Bruises or bleeding of the genitalia, perineum, or perianal area
- Vaginal discharge and/or pruritus
- Recurrent urinary tract infections
- Gonococcal infection in the pharynx, urethra, or vagina
- Syphilis
- Genital herpes
- Trichomonas
- Chlamydial infection when present beyond the first six months of life (Chlamydia may be present at birth and remain viable for up to six months.)
- Lymphogranuloma venereum
- Nonspecific vaginitis
- Candidiasis
- Pregnancy
- Sperm or acid phosphate on body or clothes; sperm in the urine of a female child
- Lax rectal tone

Physicians have a crucial role to play in sorting out the diagnosis of sexual abuse. The majority of hospitals in Iowa have guidelines for physicians to follow in conducting their evaluation of the child's status. The Iowa Department of Health has produced such a checklist. Their publication, "Protocol for the Examination and Treatment of Sex Abuse Victims" is available by contacting Ted Scurletis, M.D., Iowa Department of Public Health, Lucas Office Building, Des Moines, Iowa 50319.

Denial of critical care

I was driving by the park for the second time that day, getting ready to go in, and I saw these two kids sitting by the swings again. They'd been there in the morning but I didn't pay attention because there are houses all around, but now it was almost six. The little one wasn't any more than two, I think, and the older one couldn't have been more than five. They were barefoot...the weather had been pretty warm during the day but it was getting cold. I said "Are you lost," and the older one said "No, we're waiting for Joe." I said "Joe who? What's his name?" "Mom's boyfriend," the kid said. "I think his name is Joe. He's coming back. He's taking care of us." "Where's your Mom," I asked. "I don't know." He said. "Have you been here all day?" "Yeah," he said. "He told us not to leave." "Did you have anything to eat?" I asked. "No," he said. "We're hungry." And then he started crying. (Police officer)

Chapter 232 of the Iowa Code defines as a form of child abuse:

The failure on the part of a person responsible for the care of a child to provide the adequate food, shelter, clothing, or other care necessary for the child's health and welfare when financially able to do so or when offered financial or other reasonable means to do so. A parent or guardian legitimately practicing religious beliefs who does not provide specified medical treatment for a child for that reason alone shall not be considered abusing the child, however this provision shall not preclude a court from ordering that medical service be provided to the child where the child's health requires it.

To meet some of the categories of denial of critical care, a pattern may need to be seen, not just a single incident. The issue of finances can enter into the definition as well. Are the caretakers denying medical care even though they can afford it or are they just too poor? <u>The issues of pattern and finances however, are NOT part of the mandatory reporter's concerns</u>. The mandatory reporter's job is to report suspected neglect. It is the investigator's job to see whether the reported incident meets the definition of neglect.

Conditions for denial of critical care (neglect)

By law, the conditions that fall under denial of critical care are as follows:

Denial of or Failure to Provide Adequate Food. An observation might be that the child loses weight or fails to gain weight. There may be a condition or disease related to poor diet; there may be no food in the home or the food is contaminated or spoiled. To be legally established as neglect, this situation must be part of a pattern. Not having food in the house on one occasion is not denial of critical care. The caretaker must also either have, or have been offered, a way to obtain food. In addition there must be a threat to life or health in the situation.

Denial of or Failure to Provide Adequate Shelter. This might include lack of heat, unsanitary conditions, hazardous conditions or no shelter at all. This denial of critical care also requires a pattern and must involve a threat to life or health of the child.

Denial or Failure to Provide Adequate Clothing. This means the child's clothing is not adequate and threatens the child's health and safety. This also requires a pattern, except in cases of extreme cold where one exposure is life threatening. Sending a child out in dirty or ragged clothes does not constitute denial of critical care. Having a child dressed in clothes with animal feces would, however, since a health risk is involved.

Denial or Failure to Provide Medical Care. This situation might involve failure to seek medical and dental attention for an illness, failure to follow through on a

school evaluation report for vision or hearing problems in a way that threatens the child's life or health when the care is recommended by a physician and/or dentist. If the religious beliefs of the caretakers prohibit seeking medical attention, the situation might not be considered neglect, although the courts could still intervene so the child would receive needed medical attention.

Denial of or Failure to Provide Mental Health Care Necessary to Treat a Child's Serious Social Maladjustment. This category would apply if a child suffers from a serious social maladjustment such that a reasonable caretaker would understand this and yet the caretaker does not seek help for the child. This might include failure to follow up on a school evaluation or with a treatment plan developed at a mental health center.

Gross Failure to Meet the Child's Emotional Needs Necessary for Normal Development. This condition exists when a caretaker's emotional neglect is identifiable and the child has observable developmental problems. (The term gross failure means extreme.) Some situations would include failure to thrive syndrome, or when developmental milestones don't appear, or mental or emotional injuries are identified which are related to parental inattention. Emotional maltreatment includes blaming, belittling or rejecting a child; constantly treating siblings unequally; and persistent lack of concern by the caretaker for the child's welfare.

Denial of or Failure to Provide Proper Supervision Which a Reasonable and Prudent

Person Would Exercise Under Similar Facts and Circumstances and/or Cruelly or Unduly Confining a Child. The child must be considered to be unsafe in a situation. Examples might include leaving an infant in a bath tub or near an open flame, leaving a child not capable of supervising himself without supervision, or knowingly selecting a babysitter who isn't capable of insuring the safety of the child, or locking a child in a closet, attic, or basement.

Behavioral indicators of denial of critical care

Behavior in the child indicating denial of critical care can include:

- begging or stealing food
- constantly falling asleep in class
- erratic school attendance
- addiction to alcohol or drugs
- engaging in delinquent acts
- stating that there is no one to care for or look after him/her.
- poor personal hygiene
- clothing inappropriate for the weather

While emotional maltreatment does occur alone, it often accompanies physical abuse and/or sexual abuse. Emotionally maltreated children are not always physically abused. However, physically abused children are frequently emotionally maltreated as well.

The emotionally maltreated child may demonstrate the following:

- wetting or soiling
- conduct disorders including withdrawal and anti-social behavior (cruelty, stealing, destructiveness)
- behavior extremes - appearing overly compliant, extremely passive or aggressive, very demanding or undemanding
- pseudomature behavior such as parenting other children
- emotional and intellectual immaturity
- drug or alcohol addiction
- running away from home
- attempted suicide.

The behavior of emotionally maltreated and emotionally disturbed children is similar. The clue is often in the parents. The parents of an emotionally disturbed child generally accept the existence of a problem. They are concerned about the child's welfare and actively seek help. The parents of an emotionally maltreated child often blame the child for the problem or ignore its existence, refuse offers of help, and are unconcerned about the child's welfare.

Prereporting procedures

Elise was always quietly friendly with me, sometimes coming early just to sit by me or talk about this and that. But once it dawned on me that child abuse might be involved, I felt paralyzed in my interactions with her. I was afraid to even ask her how she was feeling. Everything I said to her sounded awkward and stiff. I was afraid I would be pushing her. I was afraid I was taking on too much responsibility. (teacher)

Interviewing the child

Once the suspicion of child abuse has been raised, and the mandatory reporter is deciding whether to file a report, questioning of the child must be done with a degree of care. Questioning the child about abuse can be done by a mandatory reporter, but the following guidelines should be observed:

- The questioning should be done by one person the child knows and trusts, not by a group of interviewers.
- The questioning should be done in private.
- The questioner should sit near the child in a normal manner, not poised across a table or desk.
- The questioning should be done using words the child understands.
- The child should be informed about any future action.
- The child should be allowed to use his or her own words and language without being corrected or criticized.
- The child should not be made to feel at fault or in trouble.
- The questioner should not suggest answers to the child.

- The child should not be pressed for answers he or she does not want to give.
- The questioner should not show shock and disapproval about the parents.
- The child should not be forced to remove clothing. Only a nurse or physician is allowed to undress the child.
- The child should not be told to keep the conversation hidden from the parents or caretaker.

When a child states that a particular caretaker hurt, sexually abused or neglected him, and if the statements are plausible, the child's explanation is almost always true. The issue of the child's credibility, particularly in the case of sexual abuse, has been a serious question in the courts. Research has shown overall, however, that unless there is evidence to the contrary, beyond the caretaker's denial, most children do not make up descriptions of abuse.

It is, overall, more likely that the child will not tell the truth about abuse in order to protect a caretaker or out of fear of reprisals from the caretaker. Your observations of the child, combined with the child's comments, should allow you to determine whether your suspicions of abuse are reasonable.

Interviews with parents

In most circumstances for most mandatory reporters, the parents will not be present when suspicions about abuse are raised or when questioning of a child might occur.

Guidelines for these communications with parents are contained in the next chapter. In cases of suspected sexual abuse, the parents or caretaker should decidedly not be called and informed of the concerns, except in the case of medical personnel.

Deciding to report

While some cases of abuse are fairly obvious, there may well be situations where there are legitimate doubts and the mandatory reporter is torn between fears for the safety of the child and for his or her own legal obligations, and a fear of the pain and trauma that unjustified reporting might cause. In such cases, the Child Protection Supervisor at your district Department of Human Services office, or a child protective worker at the county DHS office may be able to help.

In the next chapter, immunity from liability, procedures for the actual filing of a report, and the process that occurs after the report has been filed will be reviewed.

Review

Read the story of Ellen. Then write the answers to the questions that follow in the blanks. If you don't know the answer, turn to the page shown after the question for the information you need.

> *Frank Anderson is a school counselor in a junior high school. Ellen, who is 13, is referred to him by one of the classroom teachers because she spends most of her classtime looking out the window. While she had been a good student, she seems totally uninterested in school now and the teacher felt that she seemed depressed. After visiting the counseling office twice a week for several weeks, Ellen begins to talk about her family situation. She says that she wishes her mother wouldn't go away so much because she doesn't like being left with her new stepfather. Frank asked why. "He grabbed me so hard it hurt my arm," she says, and shows Frank some brownish bruises on her upper arms. "Why did he grab you," Frank asks. Ellen pauses. "Well, I told him I was going to tell mom that he had been touching me...you know, down there, and he grabbed me and said I'd be sorry if I ever told."*

What two kinds of abuse might Frank be reporting? (p. 19, 27)

_____

_____

What is the physical evidence that might back up Frank's report? (p. 23, 31)

_____

_____

What are Ellen's behaviors that might indicate abuse? (p. 31, 32)

_____

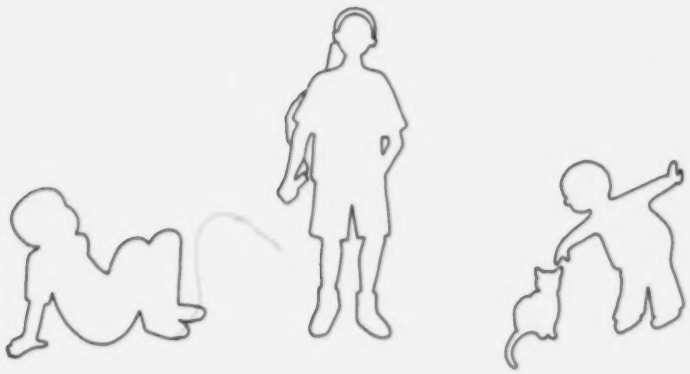
_____

What are some of the rules Frank should follow if he questions Ellen further?

(p. 40-41)

III

Making a report of suspected child abuse



AFTER READING THIS CHAPTER, YOU SHOULD BE ABLE TO ANSWER THE FOLLOWING QUESTIONS:

What occupations fall under the mandatory reporter categories?

What can happen to the mandatory reporter who doesn't report?

What are the main reasons mandatory reporters have for not reporting? To what degree are the concerns justified?

What are the correct steps for reporting abuse?

What happens after child abuse is reported?

I understand the emotional conflict that reporting child abuse puts on people. But you have to remember that often that mandatory reporter is the ONLY person who can help the child. The child can't have protection without someone taking that kind of responsibility. We had a daycare provider who saw very suspicious bruises on a child on a Wednesday. But she was concerned about her relationship with the parents and what would happen to her business if the suspicions were not confirmed and word got out to other parents. So she thought about it and finally called in and it was on a Friday evening and there was no answer at our office. She didn't know about the 24 hour number. An injury can heal while someone is deciding whether to report suspected abuse. But, the awful truth is that a child can also die while someone is deciding whether or not to report. (DHS child abuse investigator)

The mandatory reporter law in Iowa has as its expressed purpose the protection of children. Chapter 232.67 of the Code of Iowa reads:

> Children in the state are in urgent need of protection from abuse. It is the purpose and policy of this law to provide the greatest possible protection to victims or potential victims of abuse by **encouraging the increased reporting of suspected cases of abuse**, ensuring the thorough and prompt investigation of these reports, and providing rehabilitative services, where appropriate whenever possible, to abused children and their families which will stabilize the home environment so that the family can remain intact without further danger to the child.

This chapter will deal with the legal responsibility of mandatory reporters and with the actual process for correct reporting of suspected abuse. The chapter will also cover what happens after a report is made.

In review, Chapter II established that child abuse occurs to a child under the age of 18 by a caretaker responsible for the child, or who lives with the child or who provides care for the child. The definitions of abuse described in detail in Chapter 2 include physical abuse, sexual abuse, denial of critical care and prostitution.

The term "caretaker" covers certain kinds of roles in legal terms. If the person is not a caretaker, an offense might be assault and battery rather than child abuse. If a mandatory reporter suspects abuse, he or she does not have to find out whether the abusive adult meets the legal definition of caretaker.

The report should be made and DHS or law enforcement can determine whether a caretaker is involved.

Definition of mandatory reporter

Mandatory reporters include anyone who in the course of employment examines, attends, counsels or treats a child. Examples of mandatory reporters include:

Physicians, (M.D., D.O.)
Dentists
Certified Psychologists
Employees of Licensed Daycare Facilities
Members of the Staff of a Mental Health Center
Licensed Nurses
Daycare Center Workers
Dental Hygienist
Most Social Workers
Certified School Employees
Peace Officers
Chiropractors
Foster Parents
Paramedics
Counselors

Mandatory reporters *must* make reports about suspected abuse. Other people, called

permissive reporters, are not legally obligated to make reports of child abuse, but they may. Under certain circumstances, a mandatory reporter becomes a permissive reporter. For example, a school teacher is required to make a child abuse report for children in his or her school. If the teacher sees his neighbor's child being abused, he is not required to make a report, but he, as a permissive reporter, can. There may be no legal consequences to not reporting for the permissive reporter, but it suggests that there is a general moral responsibility for anyone to report suspected abuse.

Legal sanctions for failure to report

> At the end of May the child was brought again to the Arroyo Grande Community Hospital for injuries that included burned fingers, puncture wounds of the neck, and welts on the back. On this occasion strangulation marks were present and the child was not breathing. During prolonged attempts at resuscitation, and before respiration was finally restored, the child suffered so much brain damage from insufficient oxygen supply that he was ultimately institutionalized. At the time of trial, when the child was three-years-old, his I.Q. was twenty-four and his physical development was extremely retarded. The mother's "boyfriend" was convicted of child beating and sentenced from one to ten years in prison. The mother was not charged with anything. The child's father brought a $5,000,000 suit against four doctors with whom the child came in contact for failing to report the attacks, and against the police chief and "John Does, 1 to 20" of the police department for failing to investigate adequately when a fifth doctor who saw the child ultimately filed a report. The doctors who failed to report the battered child syndrome were included as defendants in the suit on a theory of negligence per se. A judgment of $600,000 was entered against the four physicians in a settlement which was the first of its kind. The money was placed in a trust fund set up for the boy and was made inaccessible to others. [13]

In Iowa any person who is a mandatory reporter who knowingly fails to report suspected child abuse is guilty of a simple misdemeanor, which can mean 30 days in

jail and a $100 fine. But more seriously, as in the case from California described above, the law states that any mandatory reporter who knowingly fails to report is liable for the damages caused by such a failure. For example, you might fail to report bruises clearly indicative of child abuse. The child is later beaten sufficiently to cause brain damage requiring tens of thousands of dollars of nursing care each year. A court could find you responsible for the costs of the child's care. Potentially, millions of dollars could be involved.

Reasons for not reporting

Most of the reasons for not reporting suspected abuse are addressed by Iowa's child abuse law. The most common reasons are the following:

Fear of Lawsuits. To help calm fears about reporting suspected abuse, the law states that if a report is made in good faith--if it isn't made in order to hurt someone or when it is known not to be true--the reporter shall have immunity from prosecution. This means that if a good faith report turns out be unfounded, the caretaker could not come back and successfully sue the reporter for damaging his or her reputation.

Reluctance to release privileged communications. Another part of the law deals with what is known as "privileged communication", such as a doctor's or mental health worker's responsibility to keep communication with a patient private. The law says that "privileged communications" does not apply in cases of child abuse. If

a physician learns that a child who is his patient is being sexually abused, the responsibility to report the abuse overrides the issue of confidentiality, even if the child asks that the information be kept secret. The husband-wife privilege is also waived in cases of child abuse.

Supervisor says not to report. Sometimes mandatory reporters will be working for an agency, such as a school or medical facility, that has procedures for reporting abuse that are important to follow. However, the individual mandatory reporter still has individual responsibility. If a supervisor decides that an incident should not be reported, and the reporter feels that there are legitimate reasons to suspect child abuse, the reporter is legally responsible to make the report anyway.

Talking to the family instead. Talking to the family personally or warning them instead of reporting will not substitute for the reporting responsibility. This excuse cuts down on the number of reports, and there is no evidence to suggest that such personal efforts can reduce abuse rates. Indeed, there is evidence to suggest that this approach maintains the child at high risk for future permanent injury or death.

I'll have to go to court. This is a concern shared, to some degree, by all mandatory reporters. The odds are greatly against a case actually going to court, and even then the reporter will not necessarily be called. Although court proceedings can be tedious and involve time away from work, a child's welfare must be seen as a more compelling interest. Nearly every court and county attorney will

go to reasonable lengths to schedule a court date for a convenient day and time. If served with a subpoena, the county attorney should be contacted to discuss these circumstances and what questions might be anticipated. The mandatory reporter can also be asked to testify at an appeal hearing at the Department of Human Services, which is a separate process from court testimony.

Not sure if it is really abuse. Child abuse investigators and law enforcement personnel find that mandatory reporters sometimes try to be too sure of their suspicions and even attempt to carry out their own investigations. Reasonable suspicion does not call for reporters to go that far before reporting suspected abuse. The mandatory reporter's job is not to be the detective or judge or jury. The reporters job is to ask appropriate agencies to look into whether abuse in fact occurred.

Preparing to report

In making your report you should have notes covering as many of the following areas as possible.

- The physical appearance of the child.
- Any observable injuries.
- The child's behavior and any statements the child makes.
- The appearance of the caretakers and any statements that the caretakers made.

Information should be as specific as possible. For example, a report that says

> *"fifty-three round 1 inch bruises varying in color from predominantly bluish-red on the left leg to brown on the right arm, the rest of the bruises being scattered on the left forehead area; there was no tenderness of the bruises or swelling; one bruise on the left cheek showed the outline of the fingers;"*

would make a considerably different impact than one that says:

> *"multiple bruises throughout the body."*

Statements as to whether a child was smelly, dirty, fearful, overly compliant, or behaving inappropriately can be of great importance in an investigation. Documenting the exact statements of a child and caretakers may require additional effort, but it is important that the investigators and others be provided an accurate picture of what happened.

Interviewing the caretakers

Usually a mandatory reporter will see a child without the caregiver. A school teacher should not make special efforts to contact the caregivers and thereby risk a confrontation, but should report suspicions to allow others to carry on an investigation. For those mandatory reporters who are more likely to have a caregiver present, careful inquiry can add to the information pool. It is not the role of the reporter to determine whether a caretaker is lying. When interviewing the caretakers the following should be kept in mind:

1. Interview each caretaker separately if possible.
2. Obtain and record any explanations given by the caretakers even if

contradictory or unlikely.

3. Maintain a non-judgmental attitude towards the caretakers.
4. Clearly explain all necessary actions on your part.
5. Try to maintain lines of communication with the caretakers.
6. Acknowledge the caretakers' possible concerns, stresses or anxieties.

FOR MEDICAL PROFESSIONALS

With most mandatory reporters, the parents will not be on the scene when the suspicions of child abuse are raised. In the case of medical personnel however, parents are quite likely to be on the scene. In these situations, questioning of the child and each of the parents or caretakers involved should be done separately.

While the reporters' names are protected by the Department of Human Services, parents may be able to figure out who made the report anyway. Thus a parent may not only be hostile, but feel that the reporter was "sneaky" or "out to get the family". To preserve credibility and because it may be morally "the right thing to do", a mandatory reporter may wish to inform the family that a report is being made. In discussing with the family the necessity to make a child abuse report, these guidelines should be observed:

1. Although informing the family that a report is to be made can be

helpful when integrated into therapeutic concerns, not everyone should attempt it.

2. The goal is not to confront the family, but rather to explain why certain actions are required.
3. Review the circumstances factually.
4. Explain your status as a mandatory reporter and penalties for failure to report.
5. Inform the family that a social worker from the Department of Human Services will be visiting them to look into the matter further.
6. If the child is being held in a hospital, explain what the goals of the admission are.
7. Try to maintain a continued line of communication even if you are met with initial resistance or hostility.

By pointing out to the family the consequences of failing to report, the focus is changed from one of active confrontation to a more passive "we have no choice" situation. If no child abuse is found, the reporter is less likely to be blamed for naming the parents as "abusers".

FOR MEDICAL PROFESSIONALS

Physicians may take x-rays and photographs of children as part of a child abuse investigation without the consent of the parents. A bone survey should be considered for all young children regardless of the type of child abuse. Some children showing symptoms of failure to thrive or sexual abuse may also have small fractures which are not obvious on physical

examination but which help to confirm a chronic pattern of multiple forms of abuse.

Physicians, can under the law, hold a child in the hospital without the parents' consent, for up to 72 hours without a court order if abuse is suspected. This prerogative is usually used if there is concern that the child's health is too unstable to allow them to leave the hospital. Consent to hold a child may be received from a juvenile court. Whether for medical or non-medical reasons, it is best if health care professionals work through the police, county attorney, or judge before invoking this physician prerogative. Do not attempt any actions which would put the child or others in physical jeopardy (such as trying to physically restrain a hostile parent).

Reporting procedures

I sat by the phone for a long time just looking at the dial. I wondered what chain of events I would be setting off for this family--the parents seemed so nice even though the bruises on Suzie's back were terrible. I also thought about how many people might have noticed Suzie's injuries in the past and couldn't bring themselves to call because of the same fears I was having. But once I made the call I felt better. Then it was no longer a dark secret between Suzie and me. It was something that could be talked about and there was something that could be done. (teacher)

While the decision to report is often a difficult one, the actual procedure for reporting is fairly simple. The mandatory reporter has two main obligations: an oral report and a written report. Both reports are kept confidential and it is up to the mandatory reporter whether to tell the caretaker about his or her involvement.

Oral report

The mandatory reporter must make an oral report within twenty-four hours to the child abuse personnel at the nearest Iowa Department of Human Services Office. The call will be handled by an intake worker or a child abuse investigator. Using a standard form, the DHS contact will ask for:

1. The names and home address of the child, parents and/or caretakers.
2. The child's present whereabouts.
3. The child's age.
4. The nature and extent of the child's injuries including any evidence of previous injuries.
5. The name, age and condition of other children in the same home.
6. Any other information which you believe might be helpful in establishing the cause of injury to the child, the identity of the person responsible for the injury or which might aid in providing assistance for the child
7. Any recommendations you might have with respect to your own profession or the child's placement.

To make a report after office hours at the Department of Human Services, there is a hotline number staffed all year at all hours: 1-800-362-2178.

In addition to the call to the Department of Human Services, some instances may warrant a call to the police as well, if there are signs that the child is in imminent danger or if sexual abuse is involved.

Written report

Within 48 hours after the oral report, you will be required to submit a written report to the Department of Human Services, covering the same information that was covered in the oral report. A sample letter that fulfills the written report requirement is shown on the following page in Figure 3.

What happens after your report is made

1. The Department of Human Services (DHS) maintains the confidentiality of the reporter's identity.
2. Immediately, upon receipt of an oral report, the Department of Human Services will make a determination as to whether the report constitutes an allegation of child abuse as defined in section 232.68.
3. DHS will respond with a visit to the child within 24 hours of receipt of the report.
4. If you indicate that the child is in imminent danger, a DHS worker will visit within one hour.
5. In some instances, DHS and the police may conduct a joint investigation.
6. In all cases, a preliminary investigation will be made by DHS within 96 hours, and a final report within two days which shall then be transmitted to the Juvenile Court, the County Attorney and the Central Registry.
7. DHS may recommend that Juvenile Court action be taken if judged necessary.

January 1, 1999

(Social Worker)
Department of Human Services
Any Town, Iowa

RE: Jane Doe, B.D. 1-1-91
18 Elm Street

Child's age, address and where-abouts

Family: Joe Doe, B.D. 5-25-95
(Brother; same address)

Mary Doe (Mother) (same address)
John Doe (Father) (same address)

Names and ages of other children in the same home
Names and addresses of caretakers

Dear (Social Worker):

Jane Doe is an 8 year-old girl who I am reporting for possible physical abuse. Today, she was seen in my classroom to have six 3" long linear bluish-red bruises (streaks) on her left upper leg and 4 on her right upper leg. The bruises were straight across and were slightly tender and swollen. When I asked Jane how she got these bruises on the back of her legs, she said "my Mommy did it". When I asked how it was done, she replied "she hit me with a stick". Jane was scared and fearful when telling me about this and didn't like anyone to see the bruises.

Nature and extent of injuries

In the past I have had concern about the parents' care of this child because she often has dirty clothes and is somewhat smelly. Because of this, she has had problems making friends with other children in school. I recommend that the family receive whatever services are necessary so that she can be safe and cleaner, and will fit in better with the other children in the classroom.

Additional pertinent information

Professional recommendation

I can be contacted at 555-1234 between 8:30 and 4:30, Monday through Friday for further information.

Sincerely,

(Your Name)
(Your Address)
(Your Telephone Number)

Reporter's name and address

Figure 3

8. The County Attorney may ask that court action be taken independent of the DHS determination.
9. All mandatory reporters will receive written notification of the outcome of their report.

Increasingly, the Department of Human Services and the local police work together to conduct a joint investigation, especially in sexual abuse cases. The county attorney may also be involved in such team efforts. The goal is to reduce the number of times the child is questioned. Such alliances are less common in cases of physical abuse and neglect although there are similar justifications for a joint approach.

A judgment will be made by the Department of Human Services as to the validity and merit of the report both for technical and content reasons:

1. The Department of Human Services may judge a report to be founded, undetermined or unfounded. Founded means that the investigation determined that child abuse occurred. Undetermined means that there was not enough evidence to draw a firm conclusion. Unfounded means that child abuse was not evident.
2. Founded reports are filed with the State Central Registry and will be sealed 10 years after the initial receipt of the report.
3. Undetermined reports are registered in the Central Registry for one year. There is very limited access to these reports and they are

"expunged" or destroyed, if no further reports or information are received.

4. Unfounded reports are listed on the Central Registry for 6 months at which time such reports are taken out of the Department of Human Services files and destroyed.

The Department of Human Services' conclusion carries considerable weight. Thus it is important that DHS be fully informed of all concerns regarding the children and that the reporter's point of view be fully communicated. Although a reporter can ask for a decision to be reviewed, in practice this is less effective than good documentation and communication of concerns in the first place. Because reports do not remain on the Central Registry indefinitely, a history of similar suspected episodes in the distant past may not be uncovered during the course of an investigation.

A Child in Need of Assistance petition (CINA) may be filed by the Department of Human Services, the juvenile court officer, or the county attorney. This then brings the child under the jurisdiction of the court which may lead to mandated services, assignment of financial responsibility, placement of the child in foster care or another setting, and the appointment of a representative for the child called the "guardian ad litem". In extreme cases, if a child has remained in foster care for a sufficient period, and dangers at home continue, termination of parental rights may take place.

Sometimes mandatory reporters may not understand why a particular conclusion was drawn from the investigation. The Department of Human Services or the County Attorney's Office can supply information on this. In addition mandatory reporters are encouraged to contact DHS or the County Attorney's office if new information appears which can add to a pattern that could call for investigation or intervention.

A conflict can develop between the goal of improving the home environment so that the family might remain intact, and the goal of seeing that there is no further danger to the child. Disagreement can persist between those who argue for the rights of parents and those who consider themselves childrens' advocates. The mandatory reporter could become dissatisfied if the outcome of the reporting process were to be settled along the lines opposite to his own philosophy. Keep in mind that it is not a contest between opposing opinions but a child's welfare that is important. If DHS, the county attorney, and/or the judge do not agree that child abuse has occurred, it does not mean that they do not share concerns for the child's welfare.

The following steps can be followed if a determination does not seem right:

1. Contact the investigating social worker.
2. Request a review through the Department of Human Services Child Protective Services Unit.
3. Pursue the case with the County Attorney or judge.
4. Continue to report if further information or new episodes occur. Each

additional report adds to the pattern and increases the chance for an effective intervention.

5. Maintain support and communication with the child and family, and try to guide them towards therapeutic solutions.

What happens to the caretakers?

The investigative report from DHS may contain a recommendation for action. In some cases, no interventions will be recommended. In others, services from the Department of Human Services or other agencies will be recommended. In the more serious cases, a recommendation will be made to refer the case to juvenile court. Approximately one half of the families involved in child abuse cases do receive some kind of therapeutic services, which means that more families involved in reports receive services than are actually found to be involved in child abuse. In some instances child abuse is not founded, such as when a parent hits a child but does not leave an injury. But the family may decide to receive services voluntarily to help deal with family stresses.

In Iowa about 3 of every 100 children are reported as being abused each year. Twenty-eight percent of these reported cases turn out to be <u>founded</u> by the Department of Human Services. The relatively low rate of founded reports should not be interpreted as meaning that reporting is a waste of time. Even when reports are <u>undetermined</u> or <u>unfounded</u>, the caretaker is notified that the community is

concerned about its children and a message is sent to the child that people care. Each time a report is added to a previously "undetermined case" it helps show a pattern which can make a case stronger in the future.

Only one of ten reported cases is judged sufficiently severe to require court action. Most cases that do result in court proceedings are handled in juvenile court, not in criminal court. The purpose of the juvenile court is to determine if a Child in Need of Assistance designation is called for, or if a case plan needs to be modified, or if a change in placement is called for, including the possibility of terminating parental rights. The standard of proof is higher in criminal court than in juvenile court. More testimony is allowed in juvenile court, including some heresay evidence. Often the evidence will be strong enough to prove child abuse in juvenile court and court action will be taken to protect the child. But the evidence may not be strong enough to bring a conviction against the caretaker in criminal court.

The concept that all child abuse is intense or represents a major risk for a child is not supported by the numbers. Frustration with the child abuse system and its perceived ineffectiveness (e.g. failure to throw the parent in jail or to remove the children from the home) has led some people to the conclusion that reporting is "pointless" or "a waste of time." It's important to remember that child abuse spans many types of maltreatment and most reports are for "minor" abuses, albeit unacceptable ones. Therefore, it is both impractical and undesirable to treat all cases with criminal legal action.

Currently, Iowa's reporting rate is comparable with other states, but the "founded" rate trails behind the national average of 40%. The Department of Human Services is studying the reasons for this discrepancy.

What happens to the children?

The statistic that is most discouraging is that nearly one third of the children involved in "founded" reports have been involved in a previous "founded" report at least once. This is similar to experiences in other states and shows that we are better at identifying abuse than in treating it. However, when mandatory reporters fail to report, it not only increases the vulnerability of children, but also makes it that much harder to learn what effective treatment is.

The mandatory reporter, depending on his or her relationship with the child and family, can play an ongoing supportive role in the child's life and the family's. Regardless of the outcome of an investigation, supportive services may be appropriate and the child and family should be encouraged to take advantage of services that are available. The mandatory reporter may be able to help protect an abused child from further abuse by maintaining contact. Perhaps most importantly, the mandatory reporter can show the caretakers that the problem can be dealt with and talked about, and that they are not "untouchables"; they will not be left alone

to deal with their guilt and sense of failure. This may be an important element in preventing further abuse.

The next chapter will deal with the issue of prevention and treatment of abuse and what we are learning is effective in these areas.

Review

Read the story of Johnny. Then write the answers to the questions in the space that follows. If you do not know the answer, turn to the page after the question for the information you need.

Barbara Lee is a physical therapist for an Area Education Agency. Most of her practice involves home visits to families with younger children with disabilities. She has been seeing Johnny Marks, a three-year-old with mild cerebral palsy, for about three months at home to instruct the mother with therapy and play activities. Johnny is walking, in braces, and is a cheerful child but difficult to feed and somewhat underweight. Mrs. Marks is an attentive mother, who has two older children. One day Barbara takes Johnny's pants off to check his braces and she notices bruises of various colors on his back and buttocks. Mrs. Marks hesitates a minute, and then says that Johnny had tripped and slid down the stairs on his back. "No one really understands how difficult having a child like Johnny is," Mrs. Marks adds. On the drive back to her office Barbara becomes more and more certain that Johnny is probably a victim of some physical abuse.

Barbara believes that Mrs. Marks and her husband may be having marital problems. She thinks she may wait until her next visit to find out more about the family situation. Is this a good idea? Why or why not? (p. 50)

_____

_____

_____

What could happen to Barbara if she doesn't report and Johnny is seriously injured in future abuse? (p. 48-49)

_____

_____

Barbara decides she must report the incident for Johnny's sake. In preparation for making a report of abuse, what are some things that Barbara should have written down about this incident? (p. 51-52)

_____

_____

It is after 5:30 when Barbara stops by her office and the county DHS office is closed. What should she do? (p. 56)

_____

_____

How soon after the call to DHS does Barbara have to write a written report?
(p. 57)

_____

_____

The report on the Marks is <u>undetermined</u>. What does this mean? (p. 59)

_____

_____

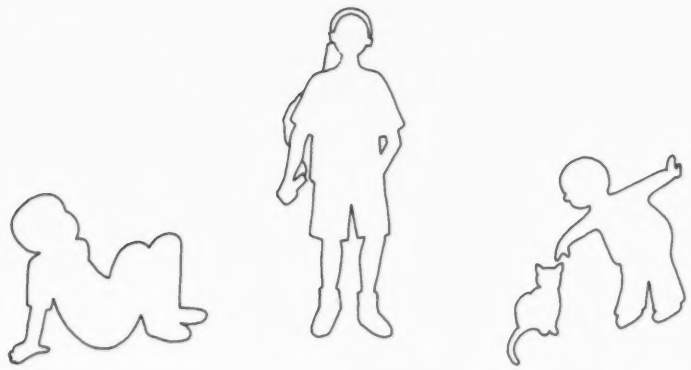
Barbara wants to know more about the investigation so she can continue to work well with Johnny and Mrs. Marks. What should she do? (p. 61)

_____

_____

IV

Preventing and treating child abuse



AFTER YOU READ THIS CHAPTER, YOU SHOULD BE ABLE TO ANSWER THE FOLLOWING QUESTIONS:

What are examples of child abuse prevention programs in Iowa?

What are some of the basic assumptions behind efforts to treat child abuse?

What are the characteristics of effective treatment programs for child abuse?

What are some specific services that may be needed for parents who have abused their children; or for the children themselves?

Twenty years ago, I had spanked my own three year old boy with a hairbrush, hard enough to leave ridgemarks on his bottom. I don't remember what he did to trigger my anger, but in my mind I can still see those little bruises...How wonderful it would have been if I could have called somebody, anybody, and talked normally and naturally about what I'd done. If only I could have aired my feelings and openly sought ways to help myself so that I could have understood episodes like those and defused them before they erupted... [14]

The goal of child abuse laws today are first to protect the child. Treatment and prevention efforts are, overall, meant to accomplish that end. But although child abuse is an assault on a child's well-being, using penalties such as jail or loss of custody in treating the parents can have an effect that increases, rather than decreases, the damage to the child. The goals of treatment and prevention, therefore, must involve addressing the family as a whole and the isolation, the stress, the feelings of self-hatred, that are part of the cycle of abuse.

There are times when I lose all perspective on what I am doing. I am sitting in a counseling session with a parent who has hurt a baby. A <u>baby</u>! I need support myself to continue to understand the connection with this person and myself; to keep in mind how the normal frustrations of raising a child are blown up into this terrible condition. (Mental health worker)

Mandatory reporters, the general public, and even professionals routinely involved in issues of child abuse, may experience anger and outrage at what has happened to some abused children. While statistics show that there is no such thing as fail-safe prevention or treatment, we also know that except in extreme cases, punishment--such as incarceration of the abusive parent--may not be in the best

interests of the child. Instead, treatment and prevention efforts need to focus on the essential problems of the caretakers that contribute to abuse: High levels of stress, lack of parenting skills and lack of understanding of normal child development and behavior. Along with these is often combined another factor. In many cases the abusive parents were abused or neglected as children themselves and they are imitating their own parenting models. They are also suffering from the long-term effects of their own abuse as children, such as low self-esteem, lack of interpersonal skills and an inability to establish trusting relationships with others. They will pass these problems on to their own children if the cycle is not stopped.

Treatment and prevention efforts can be described as primary, secondary and tertiary prevention. Primary prevention involves services available to the public at large--such things as broad scale educational efforts, respite care services, and lay health visitors. Secondary prevention includes efforts targeted at populations known to be especially at risk, such as teen mothers. Tertiary prevention--which can also be labeled treatment--are those efforts designed to prevent the reoccurrence of abuse.

Primary and secondary prevention

In 1981, Iowa passed one of the first laws to establish a child abuse prevention program. The Iowa Child Abuse Prevention Program funded 39 projects in 1986 in both rural and urban communities. These projects are supported by local

community child abuse councils, and include volunteers in the activities. Many of these programs combine primary and secondary efforts, both to the general public and to high-risk groups. Examples of prevention programs in Iowa include the following.

Lay health visitors: The presence of a new baby creates stress in any family. But for inexperienced parents, parents overwhelmed by financial or other problems, this stress can be especially serious. The lay health visitor volunteer works with new families on a short-term basis, offering friendship, support and information. Educational materials are offered on parenting and child development.

Parent aides: Parents who are at-risk for becoming abusive may have a variety of problems--low self-esteem, lack of support or difficulties with their own parents. These parents are matched with trained volunteers who listen and provide problem-solving assistance. This kind of program tries to prevent abuse by assisting clients in dealing with their problems, rather than venting their frustrations on their children.

Respite/Crisis Child Care: All parents need to have occasional time away from their children. But for people with limited finances, high quality care may not be possible. Community-supported respite care services fill this need. Some services are open one or two times a week. Others may be available 24 hours a day. The main goal for the respite care services is to reduce stress by allowing parents some

guilt-free time away from their children, to lessen the frustration and hopelessness that can lead to abuse.

Sexual abuse prevention: Sexual abuse prevention projects teach children basic personal safety, using movies, coloring books and small group discussion, to teach children about "good, bad and confusing" touching and how to get help.

Support for young mothers: Teenaged women who have children are at a higher than normal risk for becoming abusive parents. They often lack the skills, knowledge and maturity needed for child care, and they are also often single parents. These support programs offer group discussion and education meetings, and/or one-to-one support by a trained volunteer. The goal of this program is to prevent abuse by providing education and support to these young women.

Treatment/tertiary prevention

Treatment is designed to prevent future abuse after an incident of child abuse has occurred. Treatment is also sometimes offered to families where an investigation did not result in founded abuse, but where the families could clearly benefit from help and are willing to accept it. The primary goal of treatment is to protect the child. Part of this effort involves working with abusive parents to help the parents break their abusive patterns and learn how to care in a way that is rewarding for themselves and the child.

Treatment assumptions

Individuals who make recommendations for treatment or who provide treatment use some basic assumptions in their work. They believe that:

- Most parents want to be good parents.
- Most people have the capacity to change.
- Most instances of child abuse or neglect do not result from malicious premeditated acts but are caused by situational or chronic stress experienced by the caretaker.
- Most abusive or neglectful parents were abused or neglected by their parents.
- Most of those who abuse or neglect children are not mentally ill or sociopathic.
- When parents are unable to fulfill their parenting role society has a responsibility to help them.
- Families in need of help have a right to receive community services.
- Most parents will use the services they need when approached in an appropriate way.

Characteristics

In Iowa, we know that less than 30% of all the families reported for suspected

abuse/neglect require intensive treatment. Less than 10% of the reported parents will encounter intervention by the court. The most effective treatment approach is the delivery of family centered services while keeping the family together. The majority of abused children do not need to be removed from their families.

While there is much yet to learn about treatment for abusive parents, and for the children who have suffered from abuse, a great deal has been learned in the last 10 years. Some general conclusions are:

1. **Effective treatment should be of an interdisciplinary nature**. Interdisciplinary means having professionals from different disciplines share information to develop treatment recommendations. Abuse is a complex problem. Any single professional working in isolation may simply not be seeing or understanding the complete picture. A child who is sexually abused may have medical problems relating to the abuse, such as injury or disease. School work may be affected and long term social and emotional problems are likely. When, for example, a physician, a teacher and a counselor can meet to discuss a child and family and can work with the family to develop a treatment plan, the treatment will be more effective than three separately created plans would be.

2. **Effective treatment intervention must be coordinated**. DHS should involve appropriate services and serve as the case manager.

3. **Treatment goals must be clearly stated**. Caretakers should be informed of the goals of treatment and of their progress over time so new patterns of behavior can be reinforced.

4. **The problem of child abuse requires a community solution**. Child abuse needs the involvement of everyone. The solution is not limited to treating the problem after the fact so it will not reoccur. It also means prevention efforts that will improve the lives of all families and prevent child abuse in the process.

Types of treatment

Every family situation calls for an individualized approach. A treatment approach that is appropriate for one family may not be for another, even though the situation may have similarities. However, there are a number of types of help that can be used successfully depending on the circumstances. They include:

1. **Help in meeting crises**, such as a need for food, clothing, shelter, legal services, health services, or a brief respite for the parent(s) and child. Options can include financial assistance, such as public relief, or public welfare programs; job assistance from the state employment agency or legal help through a public law program. Medical help can be arranged through public assistance programs that cover the costs of medical/dental care through VA hospitals, visiting nurses, and county health nurse programs.

There are several ways that a brief respite for parent/child can be arranged. *Emergency Shelter Care* (24 hour), is one possibility. *Emergency Homemakers* can be available to the family any time of the day or night and will stay with the family around the clock, to help them over a crisis or until such time when other resources can be found and used. Some communities have a *crisis nursery* where a child can be cared for at any time when the family is experiencing a stressful situation. The nursery is open 24 hours per day and there are no limitations on how frequently it may be used. *Therapeutic Preschools* provide care and emotional support for the child and make it possible for the parents to have more time and energy to devote to solving their problems. Some of these preschools also offer counseling or therapy for the children.

Temporary removal of the child from his/her home to *foster care* may be necessary for a variety of reasons: the child has been abandoned by parents, the child may be in immediate danger of being abused, or a child's only parent may require hospitalization and therefore is unable to care for the child.

2. **Help in Developing Self-Esteem and Self-Mastery**

In family counseling, the parents need a therapist who can convey a positive regard for family members, and not be judgmental. Family members need help from counselors in decision-making. A therapist can praise positive action taken by parents with their children or in managing various aspects of their lives.

3. **Help in Overcoming Social Isolation**

Joining Parents Anonymous - Parents Anonymous is similar to Alcoholics Anonymous. It is an organization in which any abuser or potential abuser can join and participate in group sessions. The sessions operate with a professional leader or facilitator. Parents Anonymous can be of great value, but the individual must first recognize that he or she is an actual or potential abuser. Some parents may be ordered by the court to attend.

Parent - Aide Programs - Volunteers are available on a part-time basis each week. They do everything from going shopping for or with the parent, taking a child out of the home for an outing, or painting a kitchen. The parent-aide is able to take the pressure off an exhausted mother by providing friendship and support.

Through these kinds of programs, parents can gradually reduce feelings of isolation by taking part in "normal" activities such as developing friendships with neighbors and getting involved in school and community activities with their children.

4. **Help with Marital Problems**

Marital problems can be addressed through marital counseling at private social agencies or County/Community Mental Health Centers. If one or both parent(s)

is involved with substance abuse (drugs or alcohol) alcohol treatment agencies, substance abuse agency, may help. If the parent has a history of mental illness or is suicidal, the local mental health center or a private psychiatrist can assist.

5. **Help in Learning How To Parent**

Reading materials are available, as are discussion groups, which focus on the needs of children at different developmental stages and what realistic expectations at different stages might be. Parent(s) could learn from their local Area Education Agency about their child's problems and needs if the youngster is hyperactive, mentally exceptional, developmentally delayed, or has learning problems. Parents could join a group led by a professional to discuss appropriate ways to manage a child's behavior. Parents Effectiveness Training (P.E.T.) has helped some parents as has participation in Parents Anonymous.

6. **Support for the child**

Most of the efforts designed to help parents will also help support children. Some programs offer special group counseling for abused children. Termination of parental rights and adoptive placement may be necessary, but are only called for in extreme instances which are relatively rare.

Summary

While the statistics on child abuse are alarming, the availability of appropriate services, and a community commitment to understand and deal with the problem mean hope for families--and specifically for children--today. The reporting of suspected abuse is the first step in making sure that children receive the help they need.

Review

Read the story about Ann. Then write the answers to the questions that follow in the blanks. If you don't know an answer, use the page references following each question to find the material you need.

Jessica Martin is a registered nurse who works part-time in a free medical clinic that is used a great deal by "street people," particularly teenagers. Ann Smith is a twelve-year-old who came to the clinic one day complaining of stomach pains and severe headaches. Her parents, she said, wouldn't take her to a doctor. In the course of doing a physical exam, a pattern of neglect by Ann's parents became clear. Ann was often being forced to stay home from school to care for younger children. When she was in school, she was still expected to do most of the housework and cooking, and was abused verbally by both parents. Ann was underweight and anemic. She was very nervous and chewed her nails badly. Martin reported the parents for denial of critical care, but the report was determined to be "unfounded." However, counseling for Ann individually and for the family as a whole was recommended. Ann evidently told her mother that Martin had reported. Ann's mother called Martin and was at first very angry about the report. The mother said that at the age of ten, she had taken care of 4 siblings almost alone when her mother had died, and that in order for the family to make it financially, she had to use Ann sometimes as a babysitter. Martin talked calmly to the mother and said that she understood but that the counseling would be free, it might help Ann's health and give them a chance to talk about some different ways to approach their problems. Mrs. Smith said she would be interested.

What assumptions about treatment seem particularly important in the Smith's case? (p. 74)

_____

_____

Martin, as a medical representative, one of Ann's teachers, a social worker and a family therapist were all involved in developing a treatment plan. This is an example of what kind of effort? (p. 75)

_____

_____

What specific kinds of treatment services might be helpful with the Smith's and why? (p. 76-79)

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Directions for Review Quiz

Take the score card and the information card from the pocket on the back cover of the book. Using a number two lead pencil, fill out the information on the information card. Then write your name and social security number on the top of the answer card. Then read each of the twenty quiz questions. Using a # 2 lead pencil, answer each question by filling in the correct circle that corresponds to the correct answer. For example, if your answer to question 3 is false, you would fill in the circle marked "b" next to question 3 on the score card. Questions 1-15 are true false, questions 16-20 are multiple choice.

When you have completed the twenty questions, place your answer card and information card in an envelope and send to:

Iowa Child Abuse Research and Education Project
The University of Iowa
Oakdale, Iowa 52319

Your quiz will be scored by computer within two weeks. If you receive a passing score of 75% (15 correct answers), you will be sent a certificate confirming that you have passed the quiz and that you have met the mandatory training requirement.

If you do not pass the quiz the first time, you will receive a second score card so you can take the quiz a second time. Again, you will return the cards to the project.

Thank you for using this service. If you have any questions, call our toll free number: 1-800-642-6186.

Review Quiz

1. All mandatory reporters must receive two hours of training in the identification and reporting of child abuse within one year of their employment in Iowa and every five years thereafter.

   a. true
   b. false

2. Abusive caretakers are likely to have unrealistic expectations of their child.

   a. true
   b. false

3. The most common form of child sexual abuse involves the father who has sexual intercourse with his daughter.

   a. true
   b. false

4. Physical abuse typically results in serious injury.

   a. true
   b. false

5. The most common injury for physically abused children is bruises.

   a. true
   b. false

6. A small child's skeletal system is very fragile.

   a. true
   b. false

7. Child prostitution is not a form of child abuse in Iowa.

   a. true
   b. false

8. Only a nurse or physician should undress a child when a mandatory reporter suspects physical abuse.

   a. true
   b. false

9. When a child states a particular caretaker sexually abused her, the child's statement is usually true.

   a. true
   b. false

10. Physically abused children have behaviors which can be signs for mandatory reporters to use in identifying abuse.

   a. true
   b. false

11. In denial of critical care cases, the issues of pattern and family finances should not be addressed by the mandatory reporter, but by the child protection worker.

   a. true
   b. false

12. Failure to report a reasonable suspicion of child abuse could lead to a civil lawsuit and prosecution for a simple misdemeanor.

   a. true
   b. false

13. Under some circumstances, the Department of Human Services may be forced to reveal the identity of the reporter of child abuse.

   a. true
   b. false

14. The County Attorney's office receives all reports of child abuse investigations, whether founded or not, and may independently initiate legal action.

   a. true
   b. false

15. Most cases of child abuse involve intervention by the court.

   a. true
   b. false

Multiple Choice

16. Which of the following factors can be used in identifying physical abuse?

    a. a number of injuries in different stages of healing
    b. the size and shape of the injuries
    c. the location of the injuries
    d. all of the above

17. Bruises are usually cleared within:

    a. 1-2 weeks
    b. 2-4 weeks
    c. 4-6 weeks
    d. 6-8 weeks

18. When compared to non-abused children, youngsters who have been abused are likely to have:

    a. more illnesses
    b. more delinquent behavior
    c. a higher teen pregnancy rate
    d. all of the above

19. An oral report of child abuse must be made to the Department of Human Services within 24 hours. This must be followed by a written report within how many hours of the oral report?

    a. 12 hours
    b. 24 hours
    c. 48 hours
    d. 72 hours
    e. 1 week

20. If a family is being informed that a child abuse report will be made, it is helpful to mention all of the following except:

    a. why you belive they are the perpetrator(s)
    b. review of the factual circumstances (physical findings, statements made by the child and caregivers, etc.)
    c. your legal requirements to report and the penalties if you fail to do so
    d. your intention to continue to be supportive of the family

INFORMATION FORM

Name _____ Social Security # _____

Discipline _____

Address _____

_____

Are you purchasing this service? ☐Yes ☐No

If no, your employer's name _____

Address _____

_____

Name

SSN #

STUDENT NUMBER

ANSWERS

100